HEALTH RESOURCES AND SERVICES ADMINISTRATION
HIV/AIDS BUREAU
DIVISION OF SERVICE SYSTEMS
Title I Conference Call Series
"Outcome Measures"
January 8, 2002
4:00 p.m. EST

Conference Call Summary

WELCOME AND ANNOUNCEMENTS

Frances Hodge, conference call moderator opened by welcoming all participants to the January 8th, 2002 Title I conference call on "Outcome Measures". Following the welcome, Ms. Hodge introduced the following conference call presenters:

- Doug Morgan, Director, Division of Service Systems, HRSA
- Faye Malitz, Chief, Epidemiology and Data Analysis Branch, HRSA
- Johanne Messore, Deputy Chief, Western Services Branch, Division of Service Systems, HRSA
- Terry Cunningham, Grantee for the San Diego EMA.

DSS ANNOUNCEMENTS

Doug Morgan, Director, DSS, made the following announcements:

- The president will soon be signing the HHS Labor Appropriations Bill for 2002, resulting in an official 2002 budget.

- HRSA anticipates getting notices of award out in early February. Due to the new administration and changes both at HRSA and HHS, the award notices will likely undergo prolonged clearance.

- In the mailing of documents for this call, was a draft copy of a letter that Title I Grantees should have gotten in late December. This letter was generated in response to previous questions regarding the issue of reflectiveness on the Ryan White Planning Council and the requirements. It indicated the need to address reflectiveness using the definition of HIV disease including both HIV and AIDS, and indicated what to do in terms of reassessing the planning council's reflectiveness as of March 1st, 2002.

HRSA will be issuing a global condition of award that will ask for the reflectiveness as of March 1st, 2002. That condition of award will be due no later than April 15th of 2002. This special condition will be attached to your award when the notices are mailed out.

ANNOUNCEMENTS Q & A

Q: I just wanted to verify the due dates on the new reflectiveness requirement. First your letter said it's due March 1st of 2002. And so you need a new table with the reflectiveness of the planning council as of March 1st, 2002, but you don't need to receive it until April 15th?

A: D. Morgan: Yes, that is correct.

Q: With respect to the global conditions of award, would HRSA be able to mail out these global conditions of award in advance so that we could get started on them and make absolutely certain that everything was submitted in a timely fashion?

A: D. Morgan: This is not possible since they would not be final or official, and they may not reflect what would be in the final notice of that award.

PRESENTATIONS

Presenter: Faye Malitz, Chief, Epidemiology and Data Services Branch
Topic: Importance of Outcome Measure.

- Over the past three years, the HIV/AIDS Bureau has continually emphasized the importance of measuring and assessing outcomes achieved through CARE Act programs. The purpose of the Outcomes Evaluation is to assess the effectiveness of programs or services in achieving the intended results.

- The Reauthorized CARE Act places additional emphasis on the need for Outcomes Evaluation; requiring that the chief elected official of an EMA provide assurance for the establishment of a quality management program.

- Programs must assess the extent to which HIV health services provided to clients under the Title I grant are consistent with the most recent public health service guidelines for the treatment of HIV disease and opportunistic infections and, as applicable, to develop strategies for ensuring that such services are consistent with the guidelines for improvements in the access to and the quality of HIV health services.

- The HRSA HIV/AIDS Bureau has defined quality as “the degree to which a health or social service meets or exceeds established professional standards and user expectations or satisfaction”.

- The evaluation of quality of care should consider three components – first, the quality of the input, that is the structure for providing services; two, the quality of the service delivery process; and three, the quality of the outcome in order to continuously improve the system of care for individuals.

- In addition to assessing program results, grantees and planning bodies should use Outcomes Evaluation results in planning, priority setting and allocating CARE Act funds.

- Providers can use the outcomes to not only improve their services but to document the success of their programs as they seek additional funding from other public and private sources.

- It is important to clearly distinguish the concepts of outcomes measures and evaluation from process measures and evaluation. Outcomes evaluation assesses the results that derive from participation in a program. Process evaluation focuses on what activities are completed, such as what treatments or services are delivered, how they are delivered, and who has received the treatment or services.

- Both types of evaluation, as well as assessing program and service structure, should be conducted by CARE Act programs as part of a quality management program. Outcomes evaluation will determine what results were achieved as the result of a program. Structure and process evaluations will demonstrate how those results were achieved.

Presenter: **Johanne Messore, Deputy Chief, Western Services Branch, DSS**
Topic: Overview of Outcome Measures Documents

- Since the 1996 Reauthorized CARE Act, planning councils have been required to use outcomes effectiveness as a tool for setting priorities and allocating funds to ensure that the limited funding available for providing primary healthcare and related health services through CARE Act programs are being used to maintain the best possible healthcare to people living with HIV disease.

- In order to provide technical assistance to grantees in developing outcomes, DSS has developed a series of Outcome Evaluation Technical Assistance Guides. The first in the series focuses on primary care as the essential core service being provided by Title I programs to ensure optimal health status of clients.

Getting Started Guide

- The purpose of the Getting Started or "How-To" guide is to provide specific information and tools to help grantees and planning councils undertake outcomes evaluation, how to involve stakeholders, and how to set up the systems necessary to support ongoing evaluation. It is designed for those with limited experience in program evaluation. This document only provides guidance; each EMA may determine for itself what outcomes indicators and approaches it will use in evaluating program results. .

- Contents of the guide include what is meant by outcomes evaluation, and how it differs from process evaluation. Program evaluation terminology varies widely and terms mean different things to different evaluators. This guide contains common terminology that grantees can use.

- Other contents include different approaches that can be used, with a focus on moving toward evaluating systems of care, not just individual services, and how a variety of services contribute to positive client outcomes.

- The guide explains what factors need to be considered in planning and carrying out outcomes evaluation; suggests ways to involve stakeholders; including providers in the process; and, provides the step by step process that can be used to plan, implement, and refine an outcomes evaluation system. In addition, the guide has sections on how to collect and analyze outcome data and how to use the results.

- Many grantees use outside consultants to develop outcomes. The Guide describes how to hire and supervise an evaluation consultant, and how to use consultants effectively.

- Included in the guide is an extensive list of resources and references that can support the evaluation process and examples of outcome indicators for primary care and case management.

Case Management Guide

- All the guides are designed to be stand-alone documents, so many of the basic concepts are repeated in each guide.

- This guide provides standard definitions of case management; outlines the standard functions of various types of case management; and, outlines case management standards of care.

- Included are examples of a support service referral standard; information and charts on suggested outcomes and indicators for case management; and, suggested data elements and data sources, including program level outcomes

and psychosocial outcomes; quality of care standards and indicators; and use of biological markers such as slowing or preventing disease progression.

- The guide contains an extensive list of references and resources, including HRSA materials on evaluation; collecting client reported quality of life data; and collecting and abstracting outcomes and quality of care data.

- Additional copies of both of these guides can be obtained from the HRSA information center at 1-888-ASK-HRSA or the HAB Web site at www.hab.hrsa.gov (ph).

- As part of the continuing evaluation monograph series we plan to develop additional reports or guides in 2002. It is anticipated that the topic of one of these reports will be Outcomes Indicators and Evaluations for Mental Health Counseling and Treatment Services and Substance Abuse Services. An additional monograph that highlights approaches for assessing support services outcomes is also planned.

Presenter: Terry Cunningham, Grantee, San Diego EMA
Topic: Local EMA Experiences Developing Outcomes

- Working with a consultant, this initiative was undertaken in June of 2000, starting with the suggested steps for Outcome Evaluations found in the Getting Started handbook on page 15. The steps included: agree on what you want to accomplish; establish a group to oversee the evaluation process; become familiar with evaluation concepts; assess your outcomes evaluation readiness; prepare an evaluation plan and timeline; agree on outcomes and indicators to be used; plan methods of obtaining and reporting data; test your process; analyze your report findings; use results; and refine and institutionalize the outcomes evaluation system and process.

- The HIV Planning Council support staff and grantee staff chose the following five categories for outcomes development – primary care, case management, outreach, substance abuse, and food services.

- In the fall of 2000, the HIV Planning Committee, a sub-committee of the HIV Planning Council composed mostly of providers with some client involvement, became the task force responsible for the development of the outcomes.

- Many pre-meeting tasks had to be done in order for the planning committee to begin its work. These tasks included involving funded providers; people living with HIV/AIDS; planning council members and staff from both the planning council and the grantee; agreeing on meeting dates; allocating sufficient times for meetings; training participants on Outcomes Evaluations; developing clear

purpose statements and meeting agendas; arranging for appropriate rooms, setup, and equipment.

- Next was the development of the outcomes and indicators for specific service categories. This involved breaking the planning committee into four subgroups with five to seven members each. The process took two meetings, with each being nearly three hours long.

- The following items were reviewed during these meetings - the key definitions such as outcomes versus outcomes indicators; currently used outcomes and indicators in each of the programs; and the outcomes and indicators used by other programs. Agreement was reached on five to seven different outcomes as a manageable number.

- Upon completion of the outcomes development, the planning committee reviewed and approved the new outcomes and submitted them to the planning council for consideration. The planning council approved the outcomes in January of 2001.

- The next step was agreement on specific data needs and how they would be met; ensuring that agreed-upon data elements are consistently available across providers in the appropriate format; ensuring standardization of data forms.

- Providers were asked to provide input on data challenges and how to overcome them. Information collected included how an organization obtains, maintains, and reports the information for currently used outcomes and indicators; how this information is collected, reported and disseminated; and, identifying obstacles that might make it difficult to obtain or report this information.

- Participants were asked to agree on how the data should be reported to or obtained by the grantee. For example, providers can report some data monthly. However, other data may require records abstraction by a consultant or other professional. Grantee data staff participation is important since it is their job to develop the monthly data reports.

- The next step was documentation of the decisions made in order to share the information with the planning council, the grantee, and the community. Following approval by the planning council, participants were sent the final outcomes document via e-mail. These were then included in our RFP process.

- The planning committee has recently started the process for the next five service categories. And it is anticipated that the outcomes will be completed by March of 2002.

QUESTION AND ANSWER SESSION

Questions Received in Advance of the Call:

Q: Please define and distinguish between client-based and program level outcome indicators and give examples.

A: Client level outcomes are results or benefits for an individual client. Indicators of client outcomes might include CD4 counts, viral loads, or opportunistic infection incidents. These indicators would be measured over time to assess change in individual clients and be very useful at the local level and the grantee level.

Program level outcomes are results for all clients or a sample of clients receiving service. For example, a program might measure using the client level outcomes of the percent of clients with CD4 count under 200 and strive to reduce this percentage over time, thus setting a goal for the program.

Q: Other than reporting on quality of units of service provided, how would you show patient improvement for dying patients under residential hospice care?

A: Certainly, you would not look for improvements in care of people who are critically ill. But you could measure the quality of life. More importantly, you could look at satisfaction with these services from the client's viewpoint and the viewpoint of their significant others. You could also use pain management scales to make sure that your services are making the client as comfortable as possible.

Q: What specific technical assistance will HRSA provide to EMAs in developing outcome measures?

A: The Title I Needs Assessment Guide and Outcomes Evaluation Guide, as well as the Office of Science and Evaluation have publications that contain information on Outcomes Evaluation. The Title I, Title II, and Needs Assessment Guides are all being updated to reflect the 2000 reauthorization issues.

DSS can also provide onsite TA through our technical assistance contract consultants. You should contact your DSS project officer to discuss your specific TA needs. They can also provide you with guidance as you develop your evaluation program.

Another excellent resource is your peers, as demonstrated by the excellent presentation by the San Diego Grantee on this topic. Your project officers can provide you with a list of EMAs that have done a good job in developing outcomes for their services.

Q: Is HRSA going to pursue or implement any standardized outcome measures for specific service categories?"

A: Beginning in calendar year 2002, grantees and their providers will use the new CARE Act Data Report, or CADR, to provide information on the characteristics of clients served and the services provided to those clients.

All reporting providers across all titles of the CARE Act will be asked to report on the clients they serve. In addition, all providers of medical care are required to report on a variety of process and outcome measures. The final CADR report is available on the HRSA HAB Web site.

Examples of some of these measures include screening and treatment for tuberculosis, sexually transmitted infections, and hepatitis C. We look at the number of clients who are diagnosed with opportunistic infections, and the receipt of pelvic exams or pap smears by female clients. We also look at the number of clients receiving combination anti-retroviral therapy.

Q: Discuss client level outcome measures for prevention case management and peer treatment education.

A: We have two examples for these services. Outcome measures for prevention case management could include an assessment of risky behaviors and repeated measures with clients over time as the services were delivered to see if there were changes in client behavior. There are a variety of risk behavior assessment tools that are available.

Peer treatment education outcomes could be measured by assessing treatment adherence or other activities addressed by the peer treatment education.

Q: Discuss outcome measures from non-medical services such as support services.

A: Outcomes for support services should support their utility in getting people into care or maintaining them in care. An example for transportation might be a decrease in the number of missed primary care appointments. For acupuncture, it might be a reduction of pain or treatment side effects, which could be linked to greater adherence to the treatment regimen.

CONCLUSION

With no further questions, Frances Hodge turned to Doug Morgan for closing remarks:

- Title I grantees who are contemplating TA needs should begin to work with their project officers as soon as possible to finalize any TA requests.

France Hodge then concluded the call by thanking all the presenters and the callers for their participation.